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Testimony in strong opposition to SB 1076 An Act Concerning Aid in Dying for Terminally Ill Patients February 27, 2023

Senator Anwar, Rep. McCarthy Vahey, and members of the Public Health Committee:

“If assisted suicide is legal, some people’s lives will be ended without their consent, through mistakes and abuse. No safeguards have ever been enacted or proposed that can prevent this outcome, which can never be undone.” —Marilyn Golden (1954-2021), Senior Policy Analyst at the Disability Rights Education and Defense Fund

I am an autistic adult and one of the leaders of Second Thoughts Connecticut, a coalition of disabled people opposed to the legalization of assisted suicide. I also serve on the board of directors of Euthanasia Prevention Coalition-USA and previously served on the Connecticut MOLST Task Force.

Notwithstanding the attempt to add additional and mostly unworkable “safeguards” from previous iterations of this legislation, SB 1076 is fatally flawed and should be rejected.

These added safeguards are part of a deliberate bait and switch tactic by proponents to get a bill passed and then come back to amend it to gut these and other safeguards. This was openly acknowledged by J.M. Sorrell, Executive Director of Massachusetts Death with Dignity, who was quoted on a similar bill in his state, saying, [“Once you get something passed, you can always work on amendments later.”](#) This incrementalist strategy is also confirmed in [Kim Callinan’s testimony](#) for Compassion & Choices, who describes these changes from previous assisted suicide bills as “unnecessary” and claims they “will result in more patients being unable to access the law.”

Some of the new provisions are likely to be immediately challenged in court. The enhanced residency requirement in SB 1076 is at odds with lawsuits filed by Compassion & Choices in [Oregon](#) and [Vermont](#) claiming that all such residency requirements are unconstitutional. The provision in Section 21 requiring an attending physician to meet every thirty days with a patient who has been prescribed lethal drugs to either certify the patient still qualifies or to dispose of the drugs is either unworkable, unconstitutional, or both. Once a patient receives a lawfully obtained lethal concoction of DDMPH costing nearly \$1000 from a mail-order compound pharmacy, there is no way to control what happens to it. You cannot compel a patient to meet with their doctor, and it would require a search warrant to enter the patient’s private home. Moreover, seizing a lawful prescription without compensating the patient who just forked over a significant amount of money for it would violate the Due Process and [Takings Clauses](#) of the Fifth Amendment, which respectively require due process and just compensation before the government seizes someone’s property.

We are in the midst of a serious opioid epidemic, yet we do not authorize searching the private homes of people lawfully prescribed opioids for unused pills and seizing them. Simply put, no safeguard can prevent lethal drugs from being ingested by people who may have originally qualified but no longer do, nor is there any way to prevent misuse by others once lethal drugs are prescribed. In one recent case from Colorado, after the intended patient took a swallow and exclaimed “Man it burns!” (as amitriptyline in the lethal compound [burns the throat](#)), [a bystander also swallowed the lethal concoction and nearly died before being rescued by EMS personnel.](#)

The mandatory counseling provision can be met by a brief consult with a social worker affiliated with Compassion & Choices for this purpose. If the attending physician is a psychiatrist prescribing for someone whom he/she/they have diagnosed as having “terminal anorexia,” there appears to be nothing in SB 1076 to prevent this psychiatrist from self-referring the patient, as a psychiatrist can qualify for both roles.

As you are probably aware, people with a sole diagnosis of anorexia nervosa have been prescribed and have died from lethal prescriptions in both [Colorado](#) and [Oregon](#). This has even led to Compassion & Choices finally admitting to an abuse of the law. Kevin Díaz, C&C’s Chief Legal Advocacy Officer, states on the organization’s website that “[This law does not and was never intended to apply to a person whose only diagnosis is anorexia nervosa.](#)” Yet in her testimony for this bill, Kim Callinan appears to state otherwise: “There have been no documented or substantiated incidents of abuse or coercion across the authorized jurisdictions ...” Does Ms. Callinan thus approve of assisted suicide for people with a sole diagnosis of anorexia? And can we really believe a single word she says when she makes this astonishing and [demonstratively false claim](#)?

The definition of “terminal illness” in Section 1 (21) was tweaked once again, this time to read “physical medical condition.” Nothing here would exclude anorexia nervosa from qualifying, as the main symptom is physical—the patient is emaciated. Indeed, biological psychiatrists have long claimed that “mental illnesses” are “physical medical conditions,” and NAMI asserts that [“mental illnesses are physical illnesses.”](#)

Nor would the mandatory counseling requirement exclude people with anorexia from receiving lethal prescriptions, as most would meet the definition of “competent” in Section 1 (4). As psychiatrist Dr. Angela Guarda, director of the Johns Hopkins Eating Disorders Program, has [testified](#) elsewhere:

Patients with anorexia appear rational in all ways but one: they lack the capacity to accept the care they most need. Yet they meet the definition of capacity in this [assisted suicide] bill. Instilling hope is crucial for a positive therapeutic stance. How as a physician do I hold this view when I do not know which, if any of my patients are incurable? I oppose this bill because there’s too much room for error. It risks endangering the most vulnerable and the one in five Americans who suffer from a treatable mental condition.

Last year, the definition of “terminal illness” in Section 1 (21) added the words “... if the progression of such condition follows its typical course.” As [Cathy Ludlum](#) demonstrated in her powerful testimony, she qualifies for lethal drugs under this definition. As [Fabian Stahle](#) notes,

so do people with chronic conditions like insulin-dependent diabetes who reject treatment. So do people who have treatment denied by their insurance company or are otherwise unable to afford it. So do people with anorexia nervosa. Without nutrition, the “typical course” for anorexia is death in under six months. The American Clinicians’ Academy on Medical Aid in Dying (ACAMAID) has a [case report](#) in which their “Ethics Consultation Service” stated,

If the patient’s eating disorder treating physician and evaluating psychiatrist agreed that she had a “terminal disease” and retained decision-making capacity, she would meet those requirements of the aid in dying statute in her jurisdiction.

Less than two months ago, ACAMAID’s “Ethics Consultation Service” published another [case report](#), this time on Voluntary Stopping of Eating and Drinking and Medical Aid in Dying, pushing the boundaries of “terminal illness” to its logical extreme. Their members found that **“Legally, there is nothing in the letter of the law of any of the U.S. states’ aid in dying bills that explicitly prohibits accepting voluntary stopping of eating and drinking as a terminal diagnosis to qualify for aid in dying.”** They further note that allowing VSED to qualify for lethal prescriptions would **“essentially eliminate the criteria of terminal illness to qualify.”**

Thus virtually anyone at least 21 years old who is depressed, unhappy, traumatized, or lacks the will to live can qualify as “terminally ill” for a lethal prescription simply by electing to use VSED. It should be noted that some ACAMAID team members were not willing to support this position, arguing that “[e]mbarking on this could imperil the currently existing laws that allow access for terminally ill patients.” It is clear that what matters to ACAMAID, C&C, and the rest of the assisted suicide lobby is how far they can expand the law, whether by amendment or reinterpretation, without encountering pushback.

All of the ostensible safeguards in SB 1076 are rendered unenforceable and meaningless by the mere “good faith” standard in Sections 14(f) and 19. This “good faith” standard creates an unacceptable carve-out from the prevailing professional standard of care required for all other patients under [Section 52-184\(c\)](#) of the Connecticut General Statutes. As it is virtually impossible to prove that a medical provider did not act in “good faith,” providers granted legal immunity under this statute can use creative interpretations of the law, as ACAMAID has already done, to reinterpret and expand the law without resorting to amending it.

Regarding falsification of the death certificate, Section 9 (6) (b) from the 2013-2021 bills, stating “The person signing the qualified patient’s death certificate shall list the underlying terminal illness as the cause of death,” has been removed from SB 1076. In no way does this mean that death certificates will not continue to be falsified. Previous bills demonstrate clear intent to do so, as does last year’s oral testimony from death certificate certifier Shannon E. Stanford, MD, who said that “people are free to write what they want on the death certificate” (on [YouTube](#) starting at clip position 5:25:55).

In Oregon, language mandating death certificate falsification is not in statute but is in regulations, and that is certain to be the case in Connecticut. The only way to correct this is to specifically include language similar to [Oklahoma’s Death Certificate Accuracy Act](#), §63-1-316b. It states in part:

A certifier completing cause of death on a certificate of death who knows that a lethal drug, overdose or other means of assisting suicide within the meaning of Sections 3141.2 through 3141.4 of this title caused or contributed to the death, shall list that means among the chain of events under cause of death or list it in the box that describes how the injury occurred. If such means is in the chain of events under or in the box that describes how the injury occurred, the certifier shall indicate "suicide" as the manner of death.

A certifier who knowingly omits to list a lethal agent or improperly states manner of death in violation of subsection E of Section 1-317 of this title shall be deemed to have engaged in unprofessional conduct as described in paragraph 8 of Section 509 of Title 59 of the Oklahoma Statutes.

It is deeply disheartening that a bill to require honest death certificates, [HB 5486](#), was not granted a public hearing by this committee. That proposed bill would have enacted similar language here in Connecticut to the aforementioned Oklahoma statute:

That the general statutes be amended to require, upon legalization of any provision allowing the prescribing of medication to a terminally ill patient that the patient may self-administer to bring about death, a medical certifier completing cause of death on a death certificate, who knows that a lethal drug, overdose or other means of assisting suicide caused or contributed to the death, shall list such means among the chain of events under cause of death, and, if such means is in the chain of events, the certifier shall indicate "suicide" as the manner of death.

The actual purpose here is to avoid covering up foul play in a potential murder prosecution, which is the real problem with death certificate falsification as noted by [previous testimony from the Division of Criminal Justice](#).

The "accordance" language in Section 14 (c) and (d) of SB 1076 also mandates falsification of the manner of death. According to the Office of the Chief Medical Examiner, the choices in Connecticut are ["homicide," "suicide," "accidental," "natural," "therapeutic complication," or "undetermined."](#) The "accordance" language rules out homicide and suicide as a matter of law. "Accidental," "therapeutic complication," and "undetermined" are clearly ruled out, as the manner of death is both intentional and of known cause. Thus as in other states, the death will be deemed "natural," even if it was unnaturally caused by an intentional overdose of lethal drugs. This would also interfere with a potential murder prosecution.

This "accordance" language would also interfere with our state's [suicide prevention plan](#), which calls this act suicide and notes the intersection between assisted suicide and suicide prevention, particularly in regard to suicide prevention for disabled people (pp. 57-59).

No amount of change in bill language can change the fact that some people will suffer [prolonged and agonizing deaths](#) from the experimental lethal drug cocktails, with some even regaining consciousness only to die of their terminal illness. Medical science cannot guarantee the peaceful death proponents claim. If lethal injections administered for capital punishment have resulted in inhumane deaths, oral ingestion of lethal drug compounds is far more likely to

do so. We may put our pets down without their consent and for bad reasons—[because they are unwanted or have behavior problems](#)—but at least we do not make them ingest these experimental lethal compounds and make them suffer even more in the process.

No change in language can change the deadly mix between assisted suicide and a broken health care and home care system. As the cheapest “treatment,” assisted suicide diminishes choice, and especially so for [people of color](#), disabled people, and others who have been historically marginalized in our health care system.

No change in language can change the problem of misdiagnosis or the unreliability of terminal prognosis. [Jeanette Hall](#), [John Norton](#), and [Rahamim Melamed-Cohen](#) have outlived ostensibly terminal prognoses by decades. All three became staunch opponents of assisted suicide.

No change in language alters the fact that offering suicide prevention to most people while offering suicide assistance (redefined as “aid in dying”) to an ever-widening subset of disabled people is lethal disability discrimination.

The definition of “attending physician” in Section 1 (3) was modified last year, and of “consulting physician” in the current bill, to exclude someone whose practice is “primarily comprised of evaluating, qualifying and prescribing or dispensing” the lethal drugs. This is apparently an attempt at discouraging doctor shopping. It will not work because anyone can just set up a 50-50 practice with half devoted to curative or palliative care and half to assisted suicide. Moreover, the limitation does not appear to be enforceable and there are no sanctions for setting up a practice primarily devoted to assisted suicide. It also does not pertain to the person providing counseling under Section 8 of SB 1076.

The definition of “competent” allows social workers to perform capacity evaluations, and still allows someone else to speak for a patient with a communication disability.

Section 3 follows the 2015-2020 and 2022 bills in requiring two written requests and disallowing heirs and other interested parties from being witnesses to the dispensing of the lethal prescription. Nonetheless, an heir can still bring two close friends to be witnesses to a pair of faxed-in requests and allows the examination to occur via telehealth. The attending and consulting physicians may have no idea that the patient is being pressured into dying faster by an abusive heir. Moreover, there is no required independent witness at the time the lethal drugs are ingested. Many people change their minds, yet all “safeguards” end once the prescription is dispensed.

Beyond the failure of any changes to the bill language to protect against mistakes, coercion, and abuse, there is the issue of expansion. We only need to look at what Compassion & Choices and other proponents are saying, and the bills and lawsuits they have been pushing in other states. We can all remember when Compassion & Choices’ president emerita Barbara Coombs Lee came to Hartford in October 2014 declaring support for assisted suicide for people with dementia and cognitive disabilities unable to consent; in her words, [“It is an issue for another day but is no less compelling.”](#)

We can also look at recent [expansion](#) legislation and court cases being pushed by Compassion & Choices in other states, particularly those in states that already have legalized

assisted suicide, including Oregon, Washington, California, Vermont, Hawai'i, and New Mexico. Bills have provisions that would dramatically shorten and/or waive the mandatory waiting period, allow APRNs and PAs to prescribe lethal drugs, waive the requirement for a second doctor to confirm the ostensibly terminal diagnosis, allow almost anyone who does counseling for a fee to qualify in the rare case that the patient is referred for a mental health evaluation, eliminate residency requirements, allow mail-order delivery of lethal overdoses, and compel objecting providers to refer patients to other providers who will dispense lethal prescriptions.

This last provision, enacted two years ago as [California SB 380](#), is a threat to patient safety, as noted by the example of [Jeanette Hall](#), who sought to die under Oregon's law but was persuaded by her doctor to accept cancer treatment and is still alive more than 20 years later. Under a "do or refer" regime supported by Compassion & Choices, people like Jeanette Hall would have their lives cut short by years or even decades as ethical doctors will be forbidden to use their professional judgment to encourage their suicide-minded patients to seek lifesaving treatment.

So when Compassion & Choices' president Kim Callinan testifies about all of the "safeguards" in SB 1076, please remember she and her organization are working diligently to gut these same provisions in the aforementioned states that have already enacted this legislation.

Moreover, once the concept of certain people having a right to assistance with their suicides to end their suffering is codified into law, there is no limiting principle to prevent it from being extended to other disabled people who also may claim to be suffering. If SB 1076 were enacted, further expansion will move into the hands of judges. While we in the disability-rights community view legalizing assisted suicide as a violation of the Americans with Disabilities Act and the disability equal protection clause (Article XXI, amending Article V) of the Connecticut Constitution—people with certain disabilities are thus denied the benefit of suicide prevention services—judges could easily use both of these provisions to require extending the "benefit" of this "end of life option" to other disabled people. The limitations of "six months," "terminally ill," "mentally competent," and "self-administer" in SB 88 all discriminate on the basis of disability. Indeed, back in 1999, former Deputy Attorney General of Oregon David Schuman wrote [this response](#) to state senator Neil Bryant regarding the issue of self-administration:

"The Death with Dignity Act does not, on its face and in so many words, discriminate against persons who are unable to self-administer medication. Nonetheless, it would have that effect....It therefore seems logical to conclude that persons who are unable to self-medicate will be denied access to a 'death with dignity' in disproportionate numbers. Thus, the Act would be treated by courts as though it explicitly denied the 'benefit' of a 'death with dignity' to disabled people...."

Indeed, the Connecticut Supreme Court's ruling in [State v. Santiago](#), striking down a prospective repeal of the death penalty in favor of full repeal, shows how our courts can expand laws beyond the intent of this legislature using equal protection grounds. The same principle is at work with SB 1076, which gives suicide assistance to some while others get suicide prevention, and the arbitrary difference is what disability they have.

So what about the person with ALS who has a six month prognosis, but has lost the ability to self-administer? What about the person with Parkinson's disease, who will have tremors for years before dying? What about people with communication disabilities who may not be able to make the request on their own? What about Grandma with dementia, or the person with a severe psychiatric disability? Once the door to assisted suicide is pried open, Compassion & Choices will seek to open it further through the courts, going from six months terminal to one year, to perhaps five years; from assisted suicide to euthanasia; and from euthanasia for terminal illness, to chronic illness, to mental suffering. This is how we go down the same road as Canada, which has enacted Bill C-7 to allow euthanasia even for non-physical conditions, which is contemplating [extending euthanasia to minors without parental involvement](#), and where [hospitals routinely deny treatment to disabled people while offering euthanasia instead](#). For Compassion & Choices, these are merely issues for another day, and for them, no less compelling.

Legislators and the public should not be fooled by a privileged lobby that seeks to sell suicide as a solution to their own disability-phobia. We should follow the recommendations of the National Council on Disability's report, "[The Danger of Assisted Suicide Laws](#)," and reject codifying lethal and systemic disability discrimination into law.